Ontario

Inspection Report Under the
Fixing Long-Term Care Act, 2021

Ministry of Long-Term Care
Long-Term Care Operations Division
Long-Term Care Inspections Branch

Central West District
609 Kumpf Drive, Suite 105
Waterloo, ON, N2V 1K8
Telephone: (888) 432-7901

Original Public Report

Report Issue Date: May 13, 2024

Inspection Number: 2024-1585-0002

Inspection Type:
Complaint
Critical Incident

Licensee: Regional Municipality of Waterloo

Long Term Care Home and City: Sunnyside Home, Kitchener

Lead Inspector	**Inspector Digital Signature**
Brittany Nielsen (705769)	Brittany Nielsen Digitally signed by Brittany Nielsen Date: 2024.05.23 09:16:31 -04'00'

Additional Inspector(s)
Katherine Adamski (753)
Craig Michie (000690)

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): April 29-30 and May 1-3, 2024

The following intake(s) were inspected:

- Intake: #00109217 - related to a resident to resident altercation
- Intake: #00109956 - related to resident neglect
- Intake: #00110633 - related to staff to resident abuse
- Intake: #00110844 - related to an improper transfer of a resident
- Intake: #00111392 - anonymous complaint related to skin and wound concerns
- Intake: #00114425 - related to resident to resident abuse

- Intake: #00114742 - related to an injury of unknown cause

The following **Inspection Protocols** were used during this inspection:

Resident Care and Support Services
Skin and Wound Prevention and Management
Infection Prevention and Control
Responsive Behaviours
Prevention of Abuse and Neglect
Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Residents' Bill of Rights

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 3 (1) 11.
Residents' Bill of Rights
s. 3 (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
11. Every resident has the right to live in a safe and clean environment.

The licensee failed to ensure that a resident had the right to live in a clean and safe environment.

Rationale and Summary
Urine and dirty linen were left on a resident's bathroom floor for several hours. Staff said all of the items should have been cleaned up immediately.

By failing to clean up all the dirty supplies from the resident's bathroom floor, the resident was at risk of injury, as the resident transferred themselves.

Sources: interviews with staff, and record review of a resident's clinical records and the home's investigation notes.
[705769]

WRITTEN NOTIFICATION: Plan of Care

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (1) (a)
Plan of care
s. 6 (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,
(a) the planned care for the resident;

The licensee failed to ensure that a resident had a written plan of care that set out the planned care related to the resident's history of altered skin integrity.

Rationale and Summary
Over four months, several incidents of altered skin integrity were identified on a resident with no known cause.

The resident's written plan of care was reviewed and did not include a plan to prevent further altered skin integrity.

By not ensuring the resident's written plan of care set out a plan to prevent the altered skin integrity, the resident continued to sustain altered skin integrity.

Sources: a resident's clinical records and interview with staff.
[753]

WRITTEN NOTIFICATION: Transferring and Positioning Techniques

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 40
Transferring and positioning techniques
s. 40. Every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents.

The licensee failed to ensure that staff used safe transferring and positioning devices or techniques when assisting a resident.

Rationale and Summary
A resident had limited physical mobility and required extensive assistance for all transfers.

The resident had an unwitnessed fall and staff assisted them without the use of a lift.

Staff stated that they were aware of the home's no lift policy and used poor judgment to transfer the resident.

The resident's safety was at risk when they were physically transferred without a lift after they had a fall.

Sources: a resident's clinical records, the home's internal investigation, Safe Resident Handling Program Goals and Objectives (Policy #B-1-10), and interview with staff.

[753]

WRITTEN NOTIFICATION: Skin and Wound Care

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 55 (2) (b) (iv)
Skin and wound care
s. 55 (2) Every licensee of a long-term care home shall ensure that,
(b) a resident exhibiting altered skin integrity, including skin breakdown, pressure injuries, skin tears or wounds,
(iv) is reassessed at least weekly by an authorized person described in subsection (2.1), if clinically indicated;

The licensee failed to ensure that a resident who was exhibiting multiple areas of altered skin integrity was reassessed at least weekly by an authorized person described in subsection (2.1).

Rationale and Summary
Over four months, a resident had multiple areas of altered skin integrity.

Staff acknowledged that weekly skin and wound assessments were not completed on these areas of altered skin integrity and they were unable to determine the status of the injuries.

When weekly skin and wound assessments were not completed, the status of the injuries was unknown. This potentially delayed immediate treatment and interventions to reduce or relieve pain, promote healing, and prevent infection, if required.

Sources: a resident's clinical records, and interview with staff.

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WRITTEN NOTIFICATION: Continence Care and Bowel Management

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 56 (2) (g)
Continence care and bowel management
s. 56 (2) Every licensee of a long-term care home shall ensure that,
(g) residents who require continence care products have sufficient changes to remain clean, dry and comfortable; and

The licensee failed to ensure that two residents were kept clean, dry, and comfortable.

A) The licensee failed to ensure that a resident received sufficient continence care product changes to remain clean, dry, and comfortable.

Rationale and Summary
A resident was found wet from urine. Staff said the resident was changed once during the shift when they should have been checked and changed at least twice.

By failing to provide sufficient changes of the resident's continence product to allow the resident to remain clean, dry, and comfortable, they were at risk of developing skin concerns.

Sources: interviews with staff and record review of a resident's clinical records and the home's investigation notes.
[705769]

B) The licensee failed to ensure that a resident received sufficient continence care product changes to remain clean, dry, and comfortable.

Rationale and Summary
A resident was found to have feces on their skin, which was hardened onto them. Staff said the resident was changed once during the shift. The resident was to be checked and changed at least twice during the shift.

By failing to ensure the resident received sufficient changes to their continence product, they were at risk of skin breakdown.

Sources: interviews with staff and record review of a resident's clinical records and the home's investigation notes.
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